PHYSICIAN STATE/COMMUNITY MATCHING
LOAN REPAYMENT PROGRAM
COMMUNITY PARTICIPATION FORM

ND Department of Health
Division of Health Facilities
SFN 50557 (8-2001)

Dept. Use Only

File Number:

Contract Number:

Telephone: 701-328-2353

Name of Physician	
Name of Community	Name of Community Contact Person
Name of Sponsoring Organization & Address	Is County in a Federally Designated HPSA? Yes ☐ No ☐

Type of Physician the Community is Seeking (check all that apply)

☐ General Practice ☐ Family Practice ☐ General Internal Medicine

☐ General Surgery ☐ General Pediatrics ☐ General Psychiatry

☐ General Obstetrics & Gynecology

The signature below certifies that the community of _____ agrees to financially commit $_____ a year for 2 (two) years as required in the Physician Loan Repayment Program, North Dakota Century Code Chapter 43-17.2.

_____
Name of Community Representative (please type or print)

_____ _____
Signature of Community Representative Date

Return the completed form to:

Mary Amundson
Department of Community Medicine
University of North Dakota
501 North Columbia Road
P.O. Box 9037
Grand Forks, ND 58202-9037